DAY KIMBALL HOSPITAL
320 Pomfret Street, Putnam, CT 06260

Name: _____
MR # _____

AUTHORIZATION FOR BASIC TREATMENT CONDITIONS OF ADMISSION

INTRODUCTION:
This is an agreement between you and Day Kimball Hospital (the "Hospital"). It contains your agreement to pay for all services you will receive from the Hospital. It also addresses the use of your medical records (and other information about "you", "your"), insurance benefits, and certain conditions in regard to your treatment and stay at the Hospital. In consideration of receiving services, you agree as follows:

AUTHORIZATION TO PROVIDE BASIC TREATMENT AND CONDUCT BASIC AND ROUTINE DIAGNOSTIC PROCEDURES:
I authorize the performing of all routine examinations, treatments, and care provided to me under the general or specific Instructions or direction of my physician or Hospital staff. I consent to being admitted/treated as a patient of Day Kimball Healthcare and for the purpose of receiving medical care and treatment and/or diagnostic procedures. I understand that the institution and its contracted clinicians may use audio/video monitoring and consultation to enhance my care in some locations or video monitoring for patient safety.

Pursuant to Public Act 09-133, I understand that as part of the medical procedures or tests, I may be tested for HIV. I understand that HIV testing is voluntary and I can choose not to be tested for HIV or antibodies to HIV.

INFORMED CONSENT:
I understand that if I require an operation or any procedure involving a degree of risk requiring an informed consent, except in the event of emergency my own physician will discuss the risks, benefits, and alternatives and answer my questions. I am entitled to consent or refuse to consent.

MY PHYSICIAN(S) MAY BE AN INDEPENDENT CONTRACTOR:
I understand that many physicians furnishing services to me including but not limited to radiologists, pathologists and Emergency Department physicians are independent contractors and not employees or agents of the Hospital. I also understand that if I have any questions concerning the status of any health care provider as an independent contractor, employee or agent, I can ask questions. I also understand that the independent contractors occasionally wear white coats or other hospital garb and identification badges required by the Hospital, but that the use of this clothing or the use of a hospital identification badge is not intended to lead anyone to believe that the person using the clothing or the identification badge is an employee or agent of the Hospital.

RELEASE OF MEDICAL RECORDS AND OTHER INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS:
I authorize the hospital to provide from its records any information and medical records including psychiatric, substance abuse, HIV related or other confidential information ("Confidential Information") requested by my insurance/managed care company, Medicare, Medicaid, Champus, or other third party payors, hospital agents or governmental agencies in connection with payment of my bill. I also authorize the Hospital and its agents to provide Confidential Information from my medical records to any utilization, managed care, and/or quality review organization affiliated with my insurer/payor or otherwise for use in utilization management. I further authorize the Hospital to provide Confidential Information to its case management personnel, including authorization to discuss my medical care with my physicians, and to other health providers and facilities involved in discharge planning or in my continuing care after hospital discharge. I also authorize the release of Confidential Information to state or federal agencies for authorized purposes.

I have been informed that my refusal to grant consent to release of information relating to psychiatric treatment will not jeopardize my right to obtain present or future treatment except where disclosure of the communication and record is necessary for treatment. I understand that if my refusal to provide authorization results in a refusal of my insurer, managed care company or the third party payor to pay the Hospital, I will personally be responsible for the bill or the unpaid portion of the bill.

ASSIGNMENT OF BENEFITS:
I authorize third party payors, including insurers, managed care companies, and Medicare or Medicaid and other governmental payors, to make payment directly to Day Kimball Hospital, its affiliates, and any physicians involved in my care for medical expenses and any/all (Group or Direct) Hospital benefits otherwise payable to me. I understand that I am financially responsible for payment for services not covered by this authorization, and that I will pay all costs of collection of any delinquent balance including reasonable attorney's fees, which may be added to my account. I understand that my refusal to grant authorization to my third party payors will in no way jeopardize my right to obtain present or future treatment except where disclosure is necessary for treatment, but understand that under such circumstances I will be responsible for paying my bill in full. Upon request, patients may receive copies of their hospital charges. A Patient Advisor is available at 860-928-6541 (ext. 2219 or 3316), should assistance be needed.

CONSENT TO RELEASE OF SOCIAL SECURITY NUMBER TO TRACK MEDICAL DEVICES:
If in the course of my treatment I receive a medical device(s) that is traceable to its manufacturer, I authorize the release of my Social Security number to the manufacturer or its agent. I understand that the hospital has been told that my Social Security number may be used by the manufacturer to attempt to locate me if necessary in regard to this medical device.

PERSONAL VALUABLES:
I understand and agree that the Hospital maintains a safe for the safekeeping of money and valuables. I agree that if I choose not to place valuables in the Hospital safe, the Hospital will not be responsible for the loss of, or damage to my valuables. The Hospital shall not be responsible for loss or damage to items including documents, cash, dental work or dental prosthetics, eyeglasses, credit cards, hearing aids, and items of unusual value or size that have not or cannot be placed in the Hospital safe. I have been advised that any personal valuables should be given to a family member or friend for safekeeping. With the exception of items placed in the Hospital safe and for which a receipt has been issued, I agree not to make any claims against and release Day Kimball Hospital and its staff from any and all liability for any loss or damage that may occur to my personal valuables.

PATIENT RIGHTS AND RESPONSIBILITIES AND NOTICE OF PRIVACY PRACTICES:
The Hospital's Policy on Patient Rights and Responsibilities has been provided to me, and I agree to comply with such policy. Day Kimball Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATTENTION: If you speak a language other than English, are deaf or hard of hearing, language assistance services are provided free of charge. Call (860) 928-6541 ext. 2342 or ext. 2229; for TTY, dial 711 and ask to be connected to (860) 928-6541 ext. 2342 or ext. 2229.

FINANCIAL AGREEMENT:
I understand I am responsible for payment of any charges and agree to pay the hospital the regular rates or charges for all hospital and medical services rendered to me. If I am covered by a third party (for example, Blue Cross & Blue Shield or other insurance or managed care, or a benefit program such as Medicare or Medicaid), then the third party may pay all or a part of the hospital rates or charges. If so, I agree to pay those rates or charges that are not covered or paid by that third party, and to the extent permitted by law are properly payable by me, as soon as I receive a bill. If I do not pay my bill I agree to pay the hospital any collection costs including attorney's fees, collection agency fees, and court costs. The hospital reserves the right to accept periodic installment payments without waiving its rights to demand payment in full. If I do not agree, I understand a consultation with our Patient Advisor is required before non-emergent services will be rendered.

MEDICARE AND OTHER GOVERNMENTAL PROGRAMS:
I agree that the information I have given in applying for benefits under Medicare, Medicaid, Maternal or Child Health Services or other governmental programs is complete and accurate. The hospital may give the appropriate state and/or federal agencies (including but not limited to, the State Department of Social Services and the federal Social Security Administration or its fiscal intermediaries), any information about me that I have that may be necessary to process claims for such payment. The hospital, and the doctors and allied health care providers treating me may make direct claims for payment.

VETERANS:
Please indicate if you or your spouse is a veteran of the US Armed Forces. State the name of your spouse if he/she is a veteran. Please identify the branch of the Armed Forces and state the appropriate dates of service:

_____

I HAVE READ THIS PATIENT AGREEMENT, OR IT HAS BEEN READ TO ME, AND I UNDERSTAND IT, ALL OF MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION, AND I FREELY AGREE TO ALL OF THE TERMS AND CONDITIONS IN THE AGREEMENT THAT ARE APPLICABLE TO THE PATIENT EXCEPT THOSE SPECIFICALLY NOTED ABOVE BY ME AS NOT APPLYING.

****

DATE: _____ **TIME:** _____

X _____

SIGNATURE OF PATIENT

PRINT PATIENT NAME: _____

_____

SIGNATURE OF AUTHORIZED PERSONAL REPRESENTATIVE:

If a representative has signed for the patient, please state the relationship to the patient and the reason the patient did not sign:

_____

If telephone consent:

Obtained from: _____ Date: _____ Time: _____ Relationship: _____

Witness: _____ Date: _____ Time: _____ R.N.(witness) _____ Date: _____ Time: _____

DKH DAY KIMBALL HEALTHCARE

Day Kimball Hospital
320 Pomfret St. Putnam, CT 06260
Phone 860-963-6336|Fax 860-963-6482

NAME: _____ DATE OF BIRTH: _____ DEPARTMENT: _____

MODERNA COVID-19 VACCINE CONSENT FORM

	Yes	No
Are you 18 years of age or older?	☐	☐
Are you currently sick with a fever or infection?	☐	☐
Do you have a bleeding disorder or are you on a blood thinner?	☐	☐
Do you have any allergies or have you had a severe allergic reaction after a previous dose of this vaccine?	☐	☐
Are you immunocompromised or are you on a medicine that affects your immune system?	☐	☐
Are you pregnant or plan to become pregnant?	☐	☐
Are you breastfeeding?	☐	☐
Have you received another COVID-19 vaccine?	☐	☐
Have you ever had a reaction to any of the ingredients in the Moderna COVID-19 vaccine which include messenger ribonucleic acid, lipids, polyethyleneglycol, 2000 dimyristoyl glycerol, cholesterol, 1,2-distearoyl-sn-glycero-3-phosphocholine, tromethamine, tromethamine hydrochloride, acetic acid, sodium acetate and sucrose?	☐	☐

I have read or have had explained to me the current Fact Sheet for Recipients and Caregivers, Emergency Use Authorization of the Moderna COVID-19 Vaccine dated 12/2020. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the COVID-19 vaccine and ask that the vaccine be administered to me.

_____ _____ _____
Signature Date Time

PLEASE COMPLETE DEMOGRAPHICS ON BACK

For Vaccinator to complete:

Vaccine: Moderna COVID-19 Vaccine ☐ **#1** ☐ **#2**

Lot #: 018B21A **Exp. Date 9/16/21** **Site**: _____ deltoid

Administered by:_____Date:_____ Time:_____

PLEASE PRINT:

NAME: _____

STREET ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE NUMBER: _____

GENDER: _____

ETHNICITY/RACE: _____

EMPLOYER: _____